Patient Attitudes toward Mental Hospitalization: A Review of Quantitative Research
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Patient Attitudes toward Mental Hospitalization: A Review of Quantitative Research

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Much of the data available in the literature dealing with mental hospitalization from the patient's point of view stem from qualitative research. On the basis of observation, informal interviews, or masquerading as patients, social scientists have described the mental hospital and patients' attitudes toward it largely in unfavorable terms. Relatively few scientists have taken representative samples of patients, questioned them formally about the hospital via objective tests or validated scales, and displayed the findings in statistical format. The present report is a review of this body of quantitative research, with special consideration given to ascertaining patients' degree of favorableness to hospitalization. Results indicate that in 30 of the 38 different samples tested, or 78.9%, patients espoused favorable attitudes. Patients proved to be somewhat more favorable in their attitude toward mental hospitals in general than their own institution, and patients in university hospitals tended to express more positive views than those in either state or veterans' hospitals. A content analysis of the attitude measures reveals that a hospital's treatment, restrictions, organization, and amenities were rated more favorably by patients than its staff and other patients. Limited data suggest that patients' opinions of their own institution, but not of hospitals generally, change for the better between admission and discharge. Studies that compared patient and staff attitudes have inconsistent findings. Social variables had a negligible effect on the favorableness of patients' responses, but the impact of psychiatric variables was considerable. Interpretations of these results, particularly in regard to the discrepancy between qualitative and quantitative data, are offered.

For some time now the mental hospital and the patients confined there have been the objects of intensive study by social scientists.

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Since the early 1950s a number of studies have appeared dealing with those characteristics of the hospital—formal structure, informal relations, organizational functioning, staff behavior and ideology, ward environment—that impinge upon mental patients and affect the course of their illness. Typically, portraits of what it is like to be a patient in a mental hospital have been painted with *qualitative* data, by scientists observing, interviewing, or masquerading as patients. Examples of such studies are presented in Table 1. Overwhelmingly, scientists have criticized the mental hos-

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TABLE 1. Qualitative Studies of Mental Hospitalization from the Patient's View

Study	Type of Hospital	Method of Determining Patients' Views	Meaning of Hospitalization for Patients
Caudill et al. (1952)	Private	Experiences as pseudopatient	Patients suffer "pressures" to give up their defenses, accept therapy offered them, counterpose hospital personnel, and create a social life of their own.
Cumming and Cumming (1965)	State	Ex post facto inferences drawn from unstructured interview data	Patients feel a sense of "stigma"—a spoiled identity, greater social distance between them and others, shame or embarrassment.
Dunham and Weinberg (1960)	State	Observations, interactions, unstructured interviews	Patients realize they must conform to hospital norms, feel stigmatized, deny being mentally ill, disparage hospitalization, and compete with each other for release.
Goffman (1961)	State	Observations, experiences as pseudoemployee	Patients see hospital as a "total institution" with an authoritarian structure and witness a "mortification of self"—restrictions on liberties, depersonalization of relationships, loss of self-esteem, dispossession from normal social roles, abuse by staff, profanations by other patients.
Goldman et al. (1970)	State	Experiences as pseudopatient	Patients feel betrayed by friends or relatives and sustain "agitated boredom" due to the barrenness of the ward environment.
Naboisek et al. (1957)	State	"Natural history" approach, longitudinal case studies	Patients fear commitment, suffer anxiety during admission, feel threatened by their subordinate status, have unresolved conflicts about themselves and the hospital after release.
Pine and Levinson (1961)	State	Observations of ward and therapy sessions, unstructured interviews	Patients must overcome a series of "problems"—develop a new self-image, accept patient role, adapt to administration, gain control over feelings, relate to other patients, become reconciled to loss of freedom.
Rosenhan (1973)	12 different hospitals	Experiences as pseudopatient	Patients suffer powerlessness (no legal rights, loss of credibility, restricted freedoms) and depersonalization (lack of privacy, indifference from staff).
Scheff (1966)	State	Observations, interactions	Patients are forced into a deviant social role, must conform to the stereotyped behavior expected of disturbed persons.

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TABLE 1 (Continued)

Study	Type of Hospital	Method of Determining Patients' Views	Meaning of Hospitalization for Patients
Sommer and Whitney (1961)	Provincial	Unstructured interviews	Patients are branded as "failures," are rejected by staff, and accept a passive institutional role.
Stanton and Schwartz (1954)	Private	Observations, interactions, interviews	Patients feel removed from society, experience loneliness and anxiety, believe no one understands them, fear the power of the staff, conform to the informal organization of the hospital.

pital or charged that it has a deleterious effect upon patients. The hospital is generally pictured as an authoritarian system that forces patients to define themselves as mentally ill, change their thinking and behavior, suffer humiliations, accept restrictions, and adjust to institutional life. Patients, it is argued, have negative attitudes toward mental hospitalization.

In recent years, however, the conclusions drawn from these qualitative data have been challenged and the mental hospital defended. Linn (1968) contends that observational studies give us a one-sided and homogeneous conception of patienthood, and that a majority of patients, in fact, have positive attitudes, because hospitalization helps them to cope with emotional and environmental problems. Gove and Fain (1973) claim that the degree to which patients shed their former identity, undergo a process of self-mortification, and conform to the stereotyped role of the mentally ill has been greatly overstated. They think the hospital has a beneficial or benign effect, as most ex-patients show improvements in interpersonal relationships and community participation. To Townsend (1976) the impressionistic or "quasi-phenomenological" approach of the Table 1 researchers has resulted in questionable interpretations of the nature of the mental hospital, since empirical investigations of patients have consistently failed to reveal changes in their self-conceptions. A sociologist-patient confesses that before being committed, because of his familiarity with the social-psychiatric literature, he had feared institutionalization, the label of mental illness, and the disdain of friends and relatives (Killian and Bloomberg, 1975). After discharge, however, he believed that the culture and social structure of the hospital had facilitated rather than retarded his recovery; he felt the experience had been a pleasant one, and had sensed no stigma.

Exception has also been taken to the techniques employed in the qualitative studies. Even though the descriptions of the mental hospital from the patient's point of view may be insightful and thought-provoking, the data collected suffer from certain limitations. First, the accuracy of the data cannot be appraised (Reznikoff et al., 1959). There is no ready method for testing the objectivity or reliability of the inferences and experiences reported, as two or more observers with different backgrounds or training were not used. Second, the patients interviewed or observed did not constitute representative samples (Linn, 1968). We have no way of knowing how typical the anecdotes and incidents cited, usually obtained from or involving the most vocal and active members of the patient population, really are. Third, in none of the studies were patients used systematically as sources of information for gaining insight into the dynamics of mental hospitalization (Linn, 1969). Rather, they, who were the ones most deeply involved with the effects of commitment, were treated as passive or powerless participants in the hospital system rather than as informants for scientific research. Fourth, these types of data are almost impossible to quantify for individual or group comparisons (Reznikoff et al., 1959). Without testings of hypotheses and presentations of

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statistical results, observational and experiential material have limited applicability.

Studies of the kind outlined in Table 1 tend to overshadow the relatively few *quantitative* reports in the literature dealing with patient attitudes toward mental hospitalization. Seldom have social scientists taken representative samples of patients, questioned them directly about the hospital or their illness, utilized objective tests or validated scales, and presented the findings in statistical format. Several reasons have been offered to explain this neglect or lack of interest in patients' views. Weinstein (1972) and Sonn (1977) believe it is due to a "bias" among researchers, a tacit acceptance of the medical model of mental illness. Since the mentally ill (by definition) possess some kind of psychopathology and exhibit various symptomatology, their opinions of themselves or their situation are assumed to be unreliable or irrelevant and are not sought. Mayer and Rosenblatt (1974) argue that certain ideological conditions peculiar to the mental health profession account for the paucity of this type of research. Many psychologists and psychiatrists subscribe to the Freudian tenet that an individual's statements are unconscious distortions of reality and cannot be accepted at face value. Opinions expressed by patients who have cognitive impairment are thus doubly suspect. Mayer and Rosenblatt also note that the structural character of mental hospitals precludes patients' views from being taken seriously. Hospital personnel have little need to pay attention to the attitudes of patients, for patients are virtually powerless in the institution and are not represented by community organizers or pressure groups that demand changes in treatment practices. Few administrators, therapists, or researchers are interested in what patients have to say about hospital conditions unless disruptions in normal activities or confrontations occur.

The handful of quantitative works concerning patients' views of mental hospitals do not compose a unified body of knowledge. The few dozen published studies are, for the most part, disjointed. Different scientists and investigative teams have largely focused on a specific patient attitude, and have not cited many of the other attitudinal studies in their bibliographies. Most team or individual researchers, rather than using identical or similar methodological techniques, have developed and applied their own questions, tests, and scales. The purpose of this paper, therefore, is to review the quantitative studies of patient attitudes toward mental hospitalization, to draw together the diverse methodologies, findings, and conclusions. Special consideration is given here to evaluating the statistical data in terms of the degree of patients' positiveness or favorableness to hospitalization. Such a review, it is hoped, will shed light on the current controversy between the critics and defenders of mental hospitals.

Quantitative Methods and Studies

The quantitative studies of interest to us cover a wide range of topics. Patients' opinions have been sought on the mental hospital as a whole as well as some characteristic part of it, on hospitalization in general as well as on their own institution, on future aspects of hospitalization as well as past institutional experiences. To measure these different attitudes, a variety of methodological techniques have been employed. Certain researchers favored objective tests with a small number of questions or statements, whereas others constructed questionnaire scales from scores or hundreds of items. Before reviewing the major findings contained in this body of research, we will first examine the attitudes measured, methods used, and means by which the favorableness of patients' attitudes was determined. Moreover, it is important to assess the data accuracy and sample representativeness of the quantitative studies, since some researchers have rebuked the qualitative studies chiefly on these grounds.

Objective-Test Studies

Outlined in Table 2 are 18 different patient investigations that utilized objective tests to ascertain specific attitudes toward mental hospitalization. These tests include both unstructured methods (open-ended questions, a picture test, sentence completion tests) and structured methods (multiple-choice questions, rating scales, agreement-disagreement scales, semantic differential). Patient responses were by and large tabulated separately for each question or statement; in a few cases, how-

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TABLE 2. Studies Utilizing Objective Tests to Measure Patient Attitudes

Study	Type of Hospital	Patients Selected	Sample Size	Attitudes Measured	Technique	Method(s) of Determining Favorableness
Allen and Barton (1976)	University	Admissions, Discharges	95	Likes and dislikes about the hospital, suggestions for improvement	3 open-ended questions	% giving positive, neutral, or negative replies
Brady et al. (1959)[a]	Private	Admissions	142	Perceptions of hospitals in general	Picture test	% seeing hospital as helpful, neutral, or threatening
					7 incomplete statements	% giving positive, neutral, or negative replies
					4 multiple-choice questions	% receiving favorable, neutral, or unfavorable total scores
Fryling and Fryling (1960)	State	—	48	Evaluations of the hospital's ward, patient government, program, and benefits	4 open-ended questions	% giving positive, neutral, or negative replies
Goldman (1965)	Veterans'	Cross-section	139	Desire to leave or stay in the hospital	1 multiple-choice question	% wanting to leave or stay
Goldstein et al. (1972)	University	Discharges	346	Evaluation of benefits derived from hospitalization in general and particular aspects of it	4-point rating scale for 8 questions	Difference between mean ratings and midpoint of scale
Gordon and Groth (1961)	Veterans'	—	60	Conceptions of hospital characteristics	Semantic differential—6-point ratings for 9 adjective dimensions on 5 concepts	Difference between mean ratings and midpoint of scale
Gove and Fain (1973)	State	Discharges	429	Evaluation of hospital's helpfulness	1 multiple-choice question	% claiming they were helped or harmed
Gynther et al. (1963)	City	Admissions	121	Opinions of hospitals in general	4 multiple-choice questions	Difference between mean score and midpoint of scale
Jones et al. (1963)	University	Cross-section	54	Conceptualization of hospitalization	4-point agreement scale for 15 statements	Difference between mean ratings and midpoint of scale
Keith-Spiegel et al. (1970)	Veterans'	Discharges	360	Likes and dislikes about the hospital, suggestions for improvement	3 open-ended questions	% praising and criticizing the hospital
Kotin and Schur (1969)	State	Discharges	55	Evaluation of hospital's helpfulness	1 multiple-choice question	% claiming they were helped or not helped
Linn (1968, 1969)	State	Admissions	185	Expectations and fears of hospitalization	11 open-ended questions	% with favorable, ambivalent, or unfavorable replies to each question
						% above and below the median score for all questions

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TABLE 2 (Continued)

Study	Type of Hospital	Patients Selected	Sample Size	Attitudes Measured	Technique	Method(s) of Determining Favorableness
Mayer and Rosenblatt (1974)	State	Cross-section	220	Evaluation of hospital conditions	6-point agreement scale for 15 statements	Position of mean ratings in favorable, in-between, or unfavorable scale categories % having a mean average for all statements in favorable category
Morrow (1973)	State	—	64	Evaluations of hospital life	4-point rating scale for 6 items	Difference between mean ratings and midpoint of scale
Small, Small, and Gonzalez (1965)[b]	City	Admissions, Discharges	154	Acceptance of hospitalization, motivation for hospital treatment	4 open-ended questions	% accepting or rejecting the hospital % mentioning positive treatment goal
Souelem (1955)	Veterans'	Cross-section	95	Perceptions of hospitals in general	11 incomplete statements	% giving favorable, neutral, or unfavorable replies
Wing (1962)	Public	Cross-section	256	Desire to leave or stay in the hospital	1 open-ended question	% wanting to leave or stay
Zaslove et al. (1966)	University	Discharges	93	Evaluation of hospital treatment	1 open-ended question	% claiming hospital milieu helped the most

[a] See also Reznikoff et al. (1959, 1960) and Toomey et al. (1961).
[b] See also Small, Small, and Hayden (1965).

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ever, all test items were scaled together (Brady et al., 1959; Gynther et al., 1963; Linn, 1969; Souelem, 1955), and in one the results were handled both ways (Mayer and Rosenblatt, 1974). Questions were worded in such a way as to measure opinions of mental hospitals in general, expectations at the time of admission, evaluations of hospitalization or hospital characteristics at discharge or follow-up, and desires to be institutionalized or released.

None of the studies in Table 2 posed a problem in determining attitudinal favorableness. In many instances, unstructured replies had been categorized not only by content but purposefully to reflect whether mental patients were favorable, neutral, or unfavorable toward the hospital attitudes being measured (Allen and Barton, 1976; Brady et al., 1959; Fryling and Fryling, 1960; Linn, 1968, 1969; Small, Small, and Gonzalez, 1965; Souelem, 1955). Studies using rating scales had the quality of favorableness built in to the different points (Goldstein et al., 1972; Morrow, 1973), while those with agreement-disagreement scales contained statements suggesting positive or negative characteristics about the mental hospital (Jones et al., 1963; Mayer and Rosenblatt, 1974). Two studies had administered the same test, which contained multiple choices meant to be easily identifiable to patients as favorable, neutral, or unfavorable, but had tabulated the findings differently (Brady et al., 1959; Gynther et al., 1963). The semantic differential technique used by Gordon and Groth (1961) measures the dimension of favorableness through the adjectives rated. Finally, some researchers had developed categories for unstructured data or responses to multiple-choice questions that could easily be placed in a favorable-unfavorable context (Goldman, 1965; Gove and Fain, 1973; Keith-Spiegel et al., 1970; Kotin and Schur, 1969; Wing, 1962; Zaslove et al., 1966).

Assessments of the appropriateness of the methodology used for data collection and analysis revolve chiefly around the issue of reliability rather than validity. Most of the objective tests have "face validity," are measures based directly on the attitude in which the investigator is interested, and do not purport to measure attitudes or attributes not specifically revealed in the test (Selltiz et al., 1976:178). Only with indirect techniques (the picture test, sentence completion tests) are questions about validity ever raised. Such projective techniques, however, sacrifice precision in the interest of breadth and depth (Selltiz et al., 1976:365). Reliability, either in the form of consistency among judges (for unstructured data) or in stability of test scores (for structured data), is therefore the key concern. Unfortunately, not all of the Table 2 researchers checked the reliability of their data. Six of the nine studies with unstructured methods employed several independent judges, sometimes at different points in time, to reach high levels of consensus in the classification of patients' responses and to eliminate inconsistencies in interpretation (Brady et al., 1959; Fryling and Fryling, 1960; Linn, 1968; Small, Small, and Gonzalez, 1965; Souelem, 1955; Wing, 1962). Three of the 10 studies with structured methods compared test-retest responses, either for a control group or the total sample, and reported satisfactory levels of stability (Goldstein et al., 1972; Jones et al., 1963; Morrow, 1973).[1]

In the majority of the objective-test studies, samples were selected to be representative of patients coming to the hospital, leaving it, or institutionalized at a given time. In 15 cases probability-sampling plans were adopted, either via a selection of all admissions and/or discharges during several weeks or months, or a simple random sample of patients or wards. Nonprobability samples were taken in two studies (Fryling and Fryling, 1960; Morrow, 1973), and in one, sampling criteria were not reported (Gordon and Groth, 1961).

Questionnaire-Scale Studies

Methodological data for the questionnaire-scale studies to be examined, covering the same points as in Table 2, are somewhat more cumbersome to present. First, in Table 3A, 10 scales are summarized and then, in Table 3B, 25 different patient studies that used one or more of them are listed. Many of the scales were derived by factor analysis, a principal-components method of factoring with a variamax rotation to approximate orthogonal simple-structure. For each scale the different factors extracted were found to be significant and accounted for 24%–50% of the total variance. By contrast, the interval scales and sub-

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scales were developed through judges' ratings, a rational rather than an empirical grouping of items. Items were assigned values on the SAS and WES but weighted equally on the WAS. Certain scales or factors measure attitudes toward mental hospitals in general (CPH, RCI-Factor I, SAS); others tap patients' perceptions of their ward or institution (CTE, POW, RCI-Factor II, WAS, WCI, WES).

The method used to determine the degree of favorableness on the questionnaire scales in Table 3A was an analysis of the difference between patients' mean scores and the midpoint of the scale.[2] Souelem (1955) and Rice et al. (1963) were the only researchers who constructed their scales specifically to measure the favorableness of patients' views. Scores on the other eight scales reflect the degree of endorsement of particular attitudes, the content of which suggests either a favorable or unfavorable position. For example, patients' factor-scale scores have been interpreted as perceptions of "positive or negative program experiences" by Ellsworth and Maroney (1972:440) and "better or poorer ward climates" by Spiegel and Younger (1972:65).

The issue of construct validity is paramount to an evaluation of the accuracy of the questionnaire scales. These scales purport to measure various abstractions—such as perceptions of the mental hospital's order and organization, authoritarian control, or ward morale—that are attitudes presumed to be reflected in the patient's test performance but not depicted on the face of the questionnaire items. Estimates of the validity of such scales are generally obtained by correlations of scale scores with other measures of the same attitude, or with variables known to be related to the construct (Selltiz et al. 1976:173). Validational data were gathered for 7 of the 10 scales (CPH, POW, RCI, SAS-interval, WAS, WCI, WES-interval). Logical relationships between patients' attitudes toward mental hospitalization and illness behavior, ward differences, and hospital characteristics were observed to be statistically significant. Furthermore, acceptable reliability data are available for these same scales, either for the stability of test scores (CPH, POW, WAS, WES-interval) or the equivalence of alternate forms of the same questionnaire (POW, WCI, RCI, SAS-interval).

TABLE 3A. Summary Data for Ten Questionnaire Scales

Scale	Source	Type	Number[a] and Format of Items	Attitudes Measured[b]	Range[c]	Midpoint	Indication of Favorable Attitude
CPH (Colorado Psychopathic Hospital)	Kahn et al. (1963)	Factor analytic	4-point agreement scale for 100 statements	I—Authoritarian Control	9–36	22.5	Low scores on all factors
				II—Negative Orientation	9–36	22.5	
				IV—Physical Treatment	5–20	12.5	
				V—Arbitrary Restriction	3–12	7.5	
CTE (Characteristics of the Treatment Environment)	Allon et al. (1971)[d]	Factor analytic	11-point agreement scale for 72 statements	I—Active Staff	0–230	115	High scores on Factors I, II, III
				II—Fostering Patient Autonomy	0–220	110	Low scores on Factor IV
				III—Post-Hospital Orientation	0–40	20	
				IV—Staff Dominance	0–90	45	

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POW (Perception of Ward)	Ellsworth and Maroney (1972)	Factor analytic	5-point frequency of occurrence or agreement scale for 111 statements	I—Inaccessible Staff	12–60	36	High scores on Factors II, III, IV, V
				II—Involvement in Ward Management	6–30	18	Low scores on Factor I
				III—Satisfaction with Ward	12–60	36	
				IV—Receptive and Involved Staff	13–65	39	
				V—Expectation for Patient Autonomy	6–30	18	
RCI (Role-Conception Inventory)	Levinson and Gallagher (1964)	Factor analytic	6-point agreement scale for 116 statements	I—Preference for Benign Autocracy	10–70	40	Low scores on Factor I
				II—View of Hospital as Gratifying-Comforting	10–70	40	High scores on Factor II
SAS (Souelem Attitude Scale)	Souelem (1955)	Interval	Agree-disagree responses to 72 statements	Opinions of hospitals in general	.6–10.4[e]	5.5	Low scores
SAS	Graham and Lilly (1971)	Factor analytic	Agree-disagree responses to 36 statements (Form A)	I—The Beneficial Hospital	0–12	6	High scores on Factors I, III
				II—The Repulsive Hospital	0–13	6.5	Low scores on Factor II
				III—The Entertaining Hospital	0–4	2	
WAS (Ward Atmosphere Scale)	Moos and Houts (1968)	Interval	True-false responses to 206 statements	1—Order and Organization	0–10	5	High scores on subscales 1, 2, 4–12
				2—Program Clarity	0–10	5	Low scores on subscale 3
				3—Staff Control	0–10	5	
				4—Staff Permissiveness	0–10	5	
				5—Emotional Support	0–10	5	
				6—Involvement in Ward	0–10	5	
				7—Post-Hospital Orientation	0–10	5	
				8—Patient Insight	0–10	5	
				9—Patient Autonomy	0–10	5	
				10—Patient Spontaneity	0–10	5	
				11—Patient Interaction	0–10	5	
				12—Ward Variety	0–10	5	

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TABLE 3A (Continued)

Scale	Source	Type	Number[a] and Format of Items	Attitudes Measured[b]	Range[c]	Midpoint	Indication of Favorable Attitude
WCI (Ward Climate Inventory)	Spiegel and Younger (1972)	Factor analytic	6-point agreement scale for 23 statements	I—Personnel Concern for Patients	10–70	40	Low scores on all factors and total
				II—Patient Concern for Patients	5–35	20	
				III—Ward Morale	8–56	32	
				Total—Ward Climate	23–161	92	
WES (Ward Evaluation Scale)	Rice et al. (1963)	Interval	True-false responses to 69 statements	A—Physical Facilities B—Patient Services C—Patient Management Total—Ward Conditions	—	—	High scores on all subscales and total
WES	Graham et al. (1971)	Factor analytic	True-false responses to 69 statements	I—Staff Interest in Patients	0–9	4.5	High scores on all factors
				II—Cleanliness of Ward	0–9	4.5	
				III—Absence of Disturbing Noise on Ward	0–3	1.5	
				IV—Staff Permissiveness and Sensitivity	0–12	6	
				V—Patient Comfort	0–8	4	

[a] Number of items on total scale, not number of items on factors or subscales reviewed here.

[b] Only those factors or subscales dealing with the hospital are listed.

[c] Sometimes calculated from data made available through personal correspondence.

[d] The CTE scale was originally developed by Jackson (1969). Jackson's factors are different from those of Allon et al. and have not been used with patient populations.

[e] For each item on the scale.

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TABLE 3B. Studies Utilizing Questionnaire Scales to Measure Patient Attitudes

Study	Type of Hospital	Patients Selected	Sample Size	Scale(s)
Brady et al. (1959)[a]	Private	Admissions	142	SAS-interval
Ellsworth and Maroney (1972) Ellsworth et al. (1971)	Veterans'	Cross-section	1141	POW
Friedman et al. (1974) Graham et al. (1974)	State	Admissions	626	WES-factor POW, CTE
Imre (1962) Imre and Wolf (1962)	State	—	125	SAS-interval
Jones and Kahn (1964)	University	Cross-section	54	CPH
Jones and Keener (1968)	University	Admissions	27	CPH
Kahn and Jones (1969)	State, Veterans' Military University	Cross-section	140	CPH
Kahn and Weber (1972)[b]	Veterans'	Admissions, Discharges	51	CPH
Kish (1971)	Veterans'	Cross-section	169	WAS
Klass et al. (1977)	State	Discharges	431	WAS
Klett et al. (1963)	State	Cross-section	170	WES-interval
Klopfer et al. (1956)	State	—	33	SAS-interval
Konick (1971)	State	Admissions	590	SAS-factor WES-factor POW, CTE
Levinson and Gallagher (1964)	State	Admissions	100	RCI
Moos (1974)	State, Veterans' University	Cross-section	982	WAS
Moos and Houts (1968)	State, Veterans' Private, General University[c]	Cross-section	365	WAS
Moos and Houts (1970)	State, Veterans'[c]	Cross-section	186	WAS
Moos and Schwartz (1972)	Veterans'	Cross-section	292	WAS
Moos et al. (1973)	Veterans'	Cross-section	111	WAS
Pierce et al. (1972)	General	Cross-section	17	WAS
Rice et al. (1963)	Veterans'	Cross-section	397	WES-interval
Roback and Snyder (1965)	State, Veterans'	Cross-section	220	SAS-interval
Souelem (1955)	State, Veterans'	Cross-section	198	SAS-interval
Spiegel and Younger (1972)	Veterans'	Cross-section	254	WCI
Wolfensberger (1958)	State	Admissions	95	SAS-interval

[a] See also Toomey et al. (1961).
[b] See also Weber and Kahn (1973).
[c] Hospital samples were not differentiated in the presentation of data.

Representative samples, in terms of either patient admissions, discharges, or cross-sections, were used in 23 of the studies in Table 3B. Klopfer et al. (1956) selected patients in a nonrandom manner, and Imre (1962) omitted this information.

FAVORABLENESS OF PATIENTS' ATTITUDES

The overall favorableness of patients' attitudes was determined by counting the number of different hospital *samples*, for which data

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were available and tabulated separately, that had findings "in a favorable direction." This was defined as either (1) more than half the patients viewing mental hospitalization positively or the total sample receiving a mean score on the better side of the midpoint, if a single scoring technique was adopted, or (2) a majority of positive responses or mean scores on the better side of the midpoint if multiple questions, tests, scales, subscales, or factors were used. Thus, of the 38 different samples from Table 2 and Table 3B studies that could be counted,[3] patients tended to espouse favorable attitudes in 30 (78.9%). Of those studies utilizing a single score, 12 samples met the specific criteria (Allen and Barton, 1976; Gove and Fain, 1973; Gynther et al., 1963; Imre, 1962; Klopfer et al., 1956; Kotin and Schur, 1969; Linn, 1969; Mayer and Rosenblatt, 1974; Roback and Snyder, 1965; Wolfensberger, 1958; Zaslove et al., 1966) and 2 did not (Goldman, 1965; Wing, 1962). Of those studies with multiple responses or scores, patients were favorable to hospitalization on every question, test, scale, subscale, or factor in 9 samples (Ellsworth and Maroney, 1972; Gordon and Groth, 1961; Kahn and Jones, 1969; Morrow, 1973; Souelem, 1955), were favorable on a majority of attitude measures in 9 (Fryling and Fryling, 1960; Goldstein et al., 1972; Jones et al., 1963; Kish, 1971; Konick, 1971; Moos, 1974:60;[4] Spiegel and Younger, 1972; Toomey et al., 1961), and were unfavorable or ambivalent toward hospitals in 6 (Keith-Spiegel et al., 1970; Klass et al., 1977; Levinson and Gallagher, 1964:75–79; Moos, 1974:60;[5] Pierce et al., 1972; Small, Small, and Gonzalez, 1965).

The data indicate that the frequency of favorable results varied somewhat according to the type of attitude measured. All 4 objective-test studies dealing with general opinions or conceptions showed that patients think positively of mental hospitals (Gynther et al., 1963; Jones et al., 1963; Souelem, 1955; Toomey et al., 1961). However, concerning evaluations, expectations, and opinions of one's own institution, 4 of the 14 remaining Table 2 studies did *not* observe favorable results (Keith-Spiegel et al., 1970; Goldman, 1965; Small, Small, and Gonzalez, 1965; Wing, 1962). In questionnaire-scale studies, the degree of favorableness was similarly greater on scales, subscales, or factors relating to mental hospitalization in general. On the CPH, SAS-factor, and SAS-interval scales, the 12 patient samples studied perceived all factors or had total mean scores in a favorable direction; only Factor I of the RCI yielded an unfavorable score. By contrast, many of the subscales or factors measuring perceptions of ward or institutional experiences produced unfavorable scores in cases of particular Table 3A scales used with Table 3B study samples. On the POW (Ellsworth and Maroney, 1972) all factors received favorable scores, as did Factor II of the RCI, but about two-thirds of the measures were endorsed in 6 cases with the CTE, POW, WAS, and WCI (Kish, 1971; Konick, 1971; Moos, 1974:60; Spiegel and Younger, 1972) and fewer than half in 4 cases with the WES and WAS (Klass et al., 1977; Konick, 1971; Moos, 1974:60; Pierce et al., 1972).

Results also varied according to the type of hospital sampled. Two different but complementary methods of data analysis both indicated that mental patients in university hospitals tend to express more positive views than those in either state or veterans' hospitals. First, for all studies the frequency of favorable attitudes across institutional types can be compared. Here scores in a favorable direction were counted for 74% of the patient samples taken from state (or public) facilities; for samples from veterans' and university hospitals, 80% and 100% of the studies, respectively, met one of the two criteria for positiveness. Second, the data of several investigators who compared two or more types of hospitals lend support to these findings. Attitudinal differences did not surface between patients at state and veterans' hospitals (Kahn and Jones, 1969; Moos, 1974:60; Souelem, 1955), but those at university hospitals proved to be more favorable (Kahn and Jones, 1969; Moos, 1974:60; Roback and Snyder, 1965).[6]

Time of study had some effect on patient attitudes toward mental hospitalization, but not in the manner expected. It was anticipated that patients' test scores over the past quarter century would reflect an increasing degree of favorableness, owing to the changes in hospital administration that have occurred. Hospitals have become less custodial since the mid-1950s, with the introduction of tranquilizing drugs and the growth of milieu therapy, and the community mental health movement, begin-

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ning in the 1960s, with its emphasis on ambulatory treatment, has spurred shorter commitments. However, the frequency of positive study results has, in fact, *decreased* slightly over time: 88% of the studies conducted (not published) in the 1950s, 77% in the 1960s, and 75% in the 1970s reported that patients perceived the hospital favorably. Methodologically, the best way to determine if time of study had affected patients' attitudes would be to compare the test scores of different samples, by type of hospital, on the same measure over a long period. Such comparisons were not possible, however, for researchers during the past 25 years have mainly developed their own measures and applied them in various institutional settings.

Many objective tests and questionnaire scales contained questions, subscales, or factors that were scored individually. These multiple measures, unlike a single score for a test or scale, depict the *content* of patients' attitudes toward mental hospitalization. Each of the 68 questions used by Table 2 researchers (Fryling and Fryling, 1960; Goldstein et al., 1972; Gordon and Groth, 1961; Jones et al., 1963; Linn, 1968; Mayer and Rosenblatt, 1974; Morrow, 1973; Small, Small, and Gonzalez, 1965) and the 105 subscales or factors given to various Table 3B patient samples (Ellsworth and Maroney, 1972; Kahn and Jones, 1969; Kish, 1971; Klass et al., 1977; Konick, 1971; Levinson and Gallagher, 1964:69–80; Moos, 1974:60; Pierce et al., 1972; Spiegel and Younger, 1972) were analyzed as to content and placed in categories. The favorableness of these measures, by category, was then tabulated for all study samples combined to explore how patients view particular characteristics of hospital wards and institutionalization. As Table 4 shows, mental hospital treatment, restrictions, organization, and amenities are perceived quite favorably. Approximately three-quarters or more of the questions, subscales, and factors dealing with these categories were endorsed by 22 different samples. However, in regard to staff and other patients, patients espouse negative attitudes almost as often as positive ones.

An important issue is whether or not patients' opinions of mental hospitals *change* during the course of their commitment. Unfortunately, only a handful of researchers tested patients at two or more time periods, so this issue cannot be given the attention it deserves. Nevertheless, the data do suggest that patients' attitudes toward hospitals in general, but not their own institution, remain unchanged as a result of hospitalization. Patients' images of "any hospital" did not change significantly after one month (Gynther et al., 1963), after two-, four-, and six-month intervals (Reznikoff et al., 1960), and between admission and discharge (Kahn and Weber, 1972). On the other hand, remarks by patients about their wards or institutionalization were more favorable after six months (Pierce et al., 1972) and prior to discharge (Allen and Barton, 1976; Small, Small, and Gonzalez, 1965). After discharge, patients again tend to change their minds about hospital experiences, but not in

TABLE 4. Favorableness of Patient Sample Responses or of Mean Scores to Attitude Questions, Subscales, and Factors—By Content

Content of Attitudes	Questions, Subscales, and Factors			
	Favorable		Unfavorable	
	N	%	N	%
Treatment[a]	29	76	9	24
Restrictions[b]	17	85	3	15
Organization[c]	16	73	6	27
Amenities[d]	7	78	2	22
Staff[e]	21	60	14	40
Patients[f]	29	59	20	41
Total	119	69	54	31

[a] E.g., benefits derived from treatment, quality of patient care, fears of hospitalization, motivation for treatment, orientation towards mental hospitals, program goals, effectiveness of therapy, acceptance of hospitalization, general milieu of the hospital.

[b] E.g., arbitrariness of restrictions, limitations imposed on patients, hospital's rules and regulations, similarities between mental hospitals and jails, difficulties in getting released, authoritarian character of the hospital.

[c] E.g., satisfaction with ward, orderliness of ward, cleanliness of ward, absence of disturbing noises on ward, building safety, recreational facilities, activities on ward.

[d] E.g., comforts of the hospital, meals, relaxation, escape from pressures, being alone at the hospital.

[e] E.g., staff's concern for patients, control over patients, permissiveness, support, sensitivity, involvement with patients, accessibility, activity on ward.

[f] E.g., patients' morale, post-hospital orientation, concern for patients, insight, autonomy, involvement in ward, spontaneity, social interactions.

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the same direction; follow-up interviews 3–18 months later revealed that attitudes became less favorable (Allen and Barton, 1976; Small, Small, and Hayden, 1965).

A number of researchers compared patients' objective-test or questionnaire-scale responses with those of hospital personnel. The findings, however, do not suggest any clear-cut patterns. Patients were significantly *more* favorable toward mental hospitalization in 6 cases—in comparison to psychiatrists (Goldstein et al., 1972; Zaslove et al., 1966), nurses (Zaslove et al., 1966), and staff groups combined (Kish, 1971; Mayer and Rosenblatt, 1974; Pierce et al., 1972). In 9 cases patients had *less* favorable attitudes than attendants (Goldman, 1965), clerical employees (Klopfer et al., 1956), and staff in general (Imre, 1962; Kahn and Weber, 1972; Klass et al., 1977; Levinson and Gallagher, 1964:75; Moos, 1974:57; Moos and Schwartz, 1972; Spiegel and Younger, 1972). The test or scale responses of patients in 6 cases were *similar* to those of attendants (Klopfer et al., 1956), nurses (Ellsworth et al., 1971; Imre and Wolf, 1962; Toomey et al., 1961), and staff (Moos et al., 1973; Rice et al., 1963). These inconsistencies in staff-patient attitudes occurred in all types of hospitals and thus cannot be explained by the different treatment settings in which the studies were conducted.

Social and Psychiatric Variables

Attitudinal differences between groups of patients within particular hospital samples were examined in many Table 2 and Table 3B studies, either by correlational, chi-square, or analysis-of-variance statistical techniques. Data are presented here for those social and psychiatric characteristics of patients or hospitalization most often reported on in the literature. The criteria adopted for determining the effect of such variables on attitudes consisted of counting (1) the number of times statistically significant group differences appeared in specific patient populations, if a single score for favorableness was given, or (2) the number of times half or more of the questions, tests, scales, subscales, or factors of each study yielded significant group differences, if multiple measures of favorableness were employed. These criteria parallel those given above to ascertain whether a total sample of patients expressed positive or negative opinions of mental hospitals.

A review of data for six social variables revealed that, for each one, studies that did not find significant differences between groups outnumbered those that did. The *age* of the patient proved to be unrelated to his/her attitude in 13 of the 16 samples in which it was taken into account (Brady et al., 1959; Ellsworth and Maroney, 1972; Friedman et al., 1974; Jones and Kahn, 1964; Linn, 1969; Moos and Houts, 1968, 1970; Rice et al., 1963; Roback and Snyder, 1965; Souelem, 1955; Wolfensberger, 1958). Gynther et al. (1963) and Klett et al. (1963) both observed that older patients were more favorable toward hospitalization than younger patients, but the reverse finding was reported by Small, Small, and Gonzalez (1965). Out of 10 studies, 8 noted that *sex* differences were negligible (Allen and Barton, 1976; Ellsworth and Maroney, 1972; Friedman et al., 1974; Gynther et al., 1963; Jones and Kahn, 1964; Moos and Houts, 1968, 1970; Small, Small, and Gonzalez, 1965). Males interviewed by Linn (1969) and females by Klett et al. (1963) were more favorable. The 3 investigations considering *race* (Friedman et al., 1974; Gynther et al., 1963; Small, Small, and Gonzalez, 1965) and the 9 looking at *education* (Brady et al., 1959; Goldman, 1965; Jones and Kahn, 1964; Kahn and Weber, 1972; Klett et al., 1963; Linn, 1969; Rice et al., 1963; Small, Small, and Gonzalez, 1965; Wolfensberger, 1958) all reported that groups did not differ significantly from one another. With respect to *social class* or *occupation*, patients in 4 out of 5 samples had similar attitudes (Allen and Barton, 1976; Brady et al., 1959; Jones and Kahn, 1964; Linn, 1969). Only Levinson and Gallagher (1964:175) found that lower class patients are more unfavorable in orientation. Finally, *marital status* was not an important variable in 6 studies out of 9 (Allen and Barton, 1976; Ellsworth and Maroney, 1972; Friedman et al., 1974; Jones and Kahn, 1964; Moos et al., 1973; Small, Small, and Gonzalez, 1965). The degree of favorableness of married patients was both greater (Gynther et al., 1963) and lesser (Goldman, 1965; Linn, 1969) in comparison to that of single and formerly married patients.

Whereas social variables had very little ef-

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fect upon patients' attitudes toward mental hospitalization, the impact of psychiatric variables was considerable. The data indicated that, for five psychiatric variables, the number of studies that observed statistically significant group differences in terms of the criteria adopted was equal to or exceeded those that did not. The patient's *diagnosis* was found to be relevant for 8 of the 14 samples in which it was considered. In most cases neurotics were more favorable than psychotics (Allen and Barton, 1976; Brady et al., 1959; Imre and Wolf, 1962; Linn, 1969; Small, Small, and Gonzalez, 1965; Wolfensberger, 1958), but in 2 studies they were less favorable (Goldstein et al., 1972; Wing, 1962), and in 5 their attitudes were similar (Ellsworth and Maroney, 1972; Friedman et al., 1974; Jones and Kahn, 1964; Moos et al., 1973; Souelem, 1955). *Time in therapy* proved to be crucial in 3 out of 5 studies—Jones and Keener (1968) and Kahn and Weber (1972) were the exceptions—yielding both a direct relationship to degree of favorableness (Goldstein et al., 1972; Levinson and Gallagher, 1964:207) and an inverse one (Brady et al., 1959). Differences between patients, based on the *type of ward* they were on, reached statistical significance in 9 of the 12 samples tested. In all nine instances, patients on "better" wards (wards that were unlocked, had high release rates, lower drop-out rates, higher staff/patient ratios, or more adequate facilities) had more positive attitudes toward mental hospitals than those on "poorer" wards (Jones and Kahn, 1964; Klett et al., 1963; Moos and Houts, 1968; Moos and Schwartz, 1972; Moos et al., 1973; Rice et al., 1963; Spiegel and Younger, 1972; Souelem, 1955). Only Ellsworth and Maroney (1972) and Roback and Snyder (1965) failed to observe these milieu differences. The 2 studies that took *type of commitment* into account both found voluntary patients to be more favorable than those who were admitted to the hospital involuntarily (Jones and Kahn, 1964; Linn, 1969). Of the 4 studies that looked at *in-hospital change* (therapists' ratings of patients' mental functioning or success in therapy), 2 found that "improved" patients were more favorable in attitude than the "unimproved" (Brady et al., 1959; Jones and Keener, 1968), and 2 noted that they were not (Graham et al., 1974; Weber and Kahn, 1973).

For two psychiatric variables, however, studies that reported statistically significant group differences were outnumbered by those that did not. The *length of hospitalization* of patients in only 3 out of 16 samples affected the favorableness of their views; patients with longer stays were more favorable (Goldman, 1965; Wing, 1962) as well as those with shorter stays (Kahn and Weber, 1972). For the most part, however, researchers found length of time in the institution to be unrelated to attitudes (Ellsworth and Maroney, 1972; Friedman et al., 1974; Jones and Kahn, 1964; Jones and Keener, 1968; Klett et al., 1963; Moos and Houts, 1968, 1970; Moos et al., 1973; Rice et al., 1963; Roback and Snyder, 1965; Souelem, 1955). Of the 8 sample studies that considered *history of previous hospitalization,* re-hospitalized patients espoused a more positive outlook than those committed for the first time in 2 of them (Gynther et al., 1963; Wolfensberger, 1958), and no such differences occurred in 6 (Brady et al., 1959; Friedman et al., 1974; Jones and Kahn, 1964; Linn, 1969; Roback and Snyder, 1965).

DISCUSSION

The findings presented in this report lead one to conclude that the picture of institutionalization drawn by patients bears little resemblance to the one sketched by the critics of mental hospitals. Social scientists who have gathered qualitative data—viz., observed the structure and functioning of hospitals, interviewed patients informally, or feigned illness to become pseudopatients—have largely argued that patients are unfavorable in attitude because of their fear of commitment, loss of freedom, subordinate status, social stigma, poor self-image, abuse by staff, removal from society, etc. However, patients responding to formal interviews and questionnaires repeatedly stress the bright, not the dark, side to hospitalization. This review of quantitative data for numerous samples representative of different types of hospital populations has revealed that a rather large majority of patients voice favorable attitudes toward mental hospitals in general as well as their own institution. Patients often claim that they (or other patients) benefit from treatment, are not bothered by restrictions, enjoy the comforts of

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the hospital, are helped by staff, gain insight into their problems, and are satisfied with ward activities. The evidence indicates that the defenders of mental hospitals have more accurately portrayed the patient's point of view than the critics.

This disparity in the meanings attached to hospitalization stems, in part, from certain methodological characteristics of the qualitative studies. Observational researchers did not focus on the patients themselves but rather on the effects of the hospital on them (Levinson and Gallagher, 1964:10–11). Ward structure, staff behavior, communication patterns, informal sanctions, and the like were the primary concerns, patients' conceptions of the hospital being referred to only secondarily. The informal interviews did not test attitudes in a systematic way, but instead were usually limited to topics that patients mentioned spontaneously, those most problematic to them at the time (Sonn, 1977:258). Such unstructured data tend to be collected via an unrepresentative sampling of patients and to not be interpreted within the context of a total hospital experience. The practice of researchers posing as patients, however, is perhaps the most glaring example of mismatched meanings. Pseudopatients consistently report the same kinds of deleterious effects of hospitalization described in the literature by other scientists (Townsend, 1976:266). Since they are not mentally ill and are therefore not in a position to benefit from treatment, they cannot possibly perceive their experiences in the same manner as do bona fide patients.

Qualitative researchers' theoretical orientations also help to explain why the negative aspects of hospitalization have been exaggerated in their findings. These social scientists were "outsiders" who critically examined the hospital with the patients' best interests at heart (Levinson and Gallagher, 1964:9–10). They generally identified with the disadvantaged patients, and, though without direct responsibility for them, were deeply concerned with their welfare. The phenomenon of institutionalization was studied—sometimes more implicitly than explicitly—via a "conversion" approach (Townsend, 1976:263). It was assumed that basic changes in patients' self-concept must occur, that the hospital forces people to perceive themselves as mentally ill and adopt a pattern of disturbed behavior. Indeed, much of the theory and very language of the observational, inferential, and experiential investigations suggest that the patient is an "unfortunate victim" of psychotherapeutic and institutional processes (Killian and Bloomberg, 1975:39). Moreover, these critics fail to even consider the possibility that the hospital's negative features may lead to positive reactions by patients. The depersonalization and powerlessness that patients allegedly experience can, instead, be the loss of social identities, roles, and statuses necessary to facilitate full participation in psychiatric treatment (Killian and Bloomberg, 1975:53).

Relationships observed in this review, plus findings from other studies, provide clues as to *why* mental patients are so favorably disposed toward hospitalization. It appears, for example, that the hospital can be a "temporary haven" for many patients. The data in this paper show that a high proportion of patients enjoy the amenities of the hospital and do not feel restricted there at all. To be protected or cared for, and to escape from the stresses of everyday life and conflicts with other people, have been found to be key motivations for admission (Hudgens, 1963:386). Furthermore, commitment often means entrance into a more attractive environment, one with better living conditions. Studies of recidivism reveal that most patients return to the hospital of their own volition, because of poverty, deprivation, inactivity, or the lack of alternatives open to them (Rosenblatt and Mayer, 1974; Spiegel and Keith-Spiegel, 1969). Furthermore, as was noted earlier, readmitted patients have never been found to be less favorable in attitude than first admissions. Finally, and perhaps most important, hospitalization seems to represent an opportunity for self-improvement. Studies have shown that attitudes toward one's own institution change for the better between admission and discharge, and that patients frequently point to the benefits of treatment. In one investigation most of the patients said they came to the hospital to get help with emotional or other difficulties (Linn, 1968:218), and in another more than two-thirds believed, one year after being released, that their ability to handle problems was now much better (Gove and Fain, 1973:499).

While patients are for the most part positive

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in orientation, several pieces of data imply that they rate the impersonal aspects of mental hospitalization higher than the personal. On both the objective tests and questionnaire scales, patients perceived or evaluated hospitals in general somewhat more favorably than they did their own institution. Patients' initially high expectations thus seem to be attenuated by their experiences following commitment. Analysis of the content of questions, subscales, and factors to which patients responded disclosed that they are more favorable to the hospital's "things" (e.g., therapy, rules and regulations, cleanliness, orderliness, meals) than its "people" (staff and patients). Perhaps it is easier for patients to blame or find fault with those components of hospitalization that they are most involved with personally.

The patients and personnel of mental hospitals have been found, in various studies, to differ significantly in their perception of mental illness (Weinstein, 1977:13). Patients have less general knowledge of psychiatry, adhere more to custodial ideology, and believe more in physical causation than do professional or treatment staff. It was anticipated, therefore, that patients would be less favorable toward the mental hospital or its ward environment than professional staff, but this was borne out in only 9 of the 21 cases summarized that compared both groups. The remaining cases were evenly split between patients being more favorable than, and as favorable as, staff in their attitudes. Thus, although in any institution there are sharp differences between its patients and personnel in social status, role expectations, and personal experiences, such differences are not always manifested in terms of attitude. The exact nature of patients' views relative to those of professional staff, perhaps controlled for occupational group and type of hospital, must await further study.

Correlations observed for three psychiatric variables lead to the conclusion that patients with less severe mental disturbances or maladaptive behavior patterns harbor more positive views of hospitalization than those more severely disturbed. The findings dealing with diagnosis, type of commitment, and in-hospital change generally pointed in one direction. Patients with neurotic disorders, voluntarily admitted, who showed improvements in symptomatology, or had success with therapy saw hospitals and their institutional experiences in more favorable terms than did psychotic, involuntary, unimproved, or less successful patients. The observation that patients in university hospitals are more often positive in their attitudes than those in state or veterans' hospitals may merely reflect the former's smaller chronic and court-committed populations. Moreover, an inspection of certain studies deemed "unrelated" to the three variables, those with multiple measures that did not meet the specific criteria for differences in degree of favorableness, provides added support for this conclusion.[7] Friedman et al. (1974:151) noted that diagnosis was related to 4 of their 14 factors, all of them dealing with hospital personnel; psychotics voiced negative views of staff significantly more often than neurotics. Similarly, Jones and Kahn (1964:406) learned that severity of mental illness was directly related to a perception of the hospital as authoritarian. Graham et al. (1974:158) discovered that patients manifesting greater reductions in thinking disturbance were more satisfied with their wards.

Data for four other psychiatric variables suggest that hospitalization per se has a lesser impact on attitudes than the character of the hospital's milieu and treatment. Results for type of ward indicated clearly that wards with more desirable characteristics (e.g., more staff, fewer elopements, better facilities) are almost uniformly perceived more favorably than the less desirable ones. Concerning time in therapy, there was a tendency toward a direct relationship to degree of favorableness. Few studies, on the other hand, met the criteria for group differences when both length of, and history of previous, hospitalization were considered. Examination of the multiple-measure studies "unrelated" to these variables strengthens the argument that the quality of patients' hospital experiences affects their perceptions more than the quantity. Patients with more time in psychotherapy less often viewed the hospital in a negative light (Kahn and Weber, 1972) and as a place of arbitrary restriction (Jones and Keener, 1968:58). However, in various questionnaire-scale studies there were few differences between patients in terms of time in the hospital or record of prior commitment. The absence of statistically significant differences based on length of hos-

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pitalization is probably due to conditions under which the studies were conducted. The definition of "long" or "short" stays varies widely by type of hospital, patients' average length of stay has decreased considerably over the past two decades, and attitudinal changes generally do not emerge until after the third month (Weber and Kahn, 1973:324).

The fact that both education and social class turned out *not* to affect patients' attitudes in any meaningful way is, in itself, a very impressive finding. For more than a quarter century, much has been written about the effects of these two variables on psychiatry and psychiatric practice. Specifically, time and again it has been argued that higher class or better educated patients hold more favorable views of psychiatrists, are more psychologically oriented, more often accept hospital restrictions and controls as therapeutic, perceive the hospital as less authoritarian, and have greater understanding of mental illness than poorly educated or lower class patients (Jones and Kahn, 1964; Levinson and Gallagher, 1964:162–200). However, none of the 9 studies dealing with education and only 1 of the 5 considering social class met the criteria for group differences in degree of favorableness. In regard to the multiple-measure "unrelated" studies, only Factor V on the CPH was correlated inversely with class. The lack of significant results, nevertheless, is consistent with recent reviews of the literature. Frank et al. (1978:62) conclude that social class differences in patient needs, expectations, and treatment preferences are, at best, mixed, and Weinstein (1977:9) contends that either social class no longer determines patients' attitudes or the process of mental hospitalization obscures class differences.

None of the six social variables reviewed here proved to be related to the manner in which patients visualize mental hospitalization. Only one multiple-measure study that did not meet the criteria for favorableness reported a few significant factor correlations for age, race, and marital status (Friedman et al., 1974:150–51). Variables intrinsic to mental illness or hospitalization seem to be far more important determinants of patients' attitudes than variables that are extrinsic. Psychiatric conditions or experiences are thus meaningful frameworks from which the hospital can be evaluated, but social characteristics, which are not causes or consequences of either illness or hospitalization, may offer patients little to base their interpretations on.

The problem of variability in the responses of patients may explain why some variables were unrelated to attitudinal favorableness. Ellsworth and Maroney (1972:441–43) maintain that while social and psychiatric characteristics of *individual* patients have negligible effects on their ward perception, characteristics of ward *populations* have quite substantial correlations with perceptions of ward climate. They found, for example, that correlations between age and diagnosis with POW scales were insignificant, but that wards with older and more chronic populations were perceived significantly more favorably than wards with younger and less chronically ill patients. Since scale scores may reflect differences in patient samples rather than real differences between wards, the proportion of variance attributable to hospital settings and that related to individual differences need to be calculated. Ellsworth and Maroney believe that researchers should use ward and population score averages in testing for the effects of social or psychiatric characteristics on attitudes. Otherwise, the relationships may very well be underestimated.

Suggestions for Future Research

The findings presented in this review suggest a number of ways in which quantitative studies of patient attitudes toward mental hospitalization can be improved. First, the validity and reliability of the data collected should always be checked and reported. Researchers who fail to assess the accuracy and appropriateness of their measures and methodologies, or fail to mention such assessments, inevitably lessen or raise doubts about the importance of their work. Second, it would be useful if the same attitudinal measures were given to patients in more than one type of institution. This would make possible more systematic comparisons of the degree of favorableness among state, veterans', university, private, and general hospital patients, and permit the time of study to be effectively considered. Third, future investigators should utilize patients' type of commitment in their analyses. Voluntary vs. in-

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voluntary admission to mental hospitals has been shown to be related to certain social and psychiatric variables (Gove and Fain, 1977; Rushing, 1978); the relation of type of admission to attitudes needs to be examined in depth. Only 2 of the 27 studies that compared patient groups within hospitals considered this variable. Fourth, anyone interested in testing patients' attitudes might try to avoid the "hit and run" approach. All too often researchers have simply collected data at one point in time, without much thought given to measuring the attitudinal changes that may occur as a result of hospitalization. Recordings of patients' attitudes at admission, discharge, and at some follow-up period admittedly are more laborious and costly, but the potential benefits of panel data are likewise greater.

Notwithstanding these tips to social scientists, perhaps the most important suggestion to them is to just *do* research on the attitudes of mental patients, to not ignore or neglect this topic. The few dozen reports reviewed here, spanning almost a quarter century, are completely dwarfed by the total number of mental hospital studies produced each year. Such research has clinical value, for it can be used by mental health therapists to understand patients better and, it is hoped, to help them overcome their emotional difficulties. Opinions taken from the "consumers" of psychiatric services are also of practical value, for they can assist administrators of hospitals (or clinics) in program planning and evaluation. That severity of illness and the character of the hospital's milieu and treatment, as we have seen, are correlated significantly with patient attitudes has important implications for different therapeutic programs. Finally, data on mental hospitalization from the patient's perspective have theoretical relevance for sociologists and psychologists in their studies of self-concept, formal organizations, sick-role behavior, socialization, and interpersonal relations.

NOTES

1. It should be noted that even if we knew that patients' structured responses in the other seven studies had produced low stability scores, this would not automatically mean that the data collected were unreliable or unworthy of review. Many of the phenomena with which social science is concerned, attitudes particularly, normally fluctuate and are expected to show variation at different testings (Selltiz et al., 1976:184–86). Indeed, an initial interview can act as a stimulus and affect subsequent test results.
2. The range and midpoint of the WES-interval scale could not be determined. These data are not given in either Rice et al. (1963) or Klett et al. (1963), and neither senior author, when contacted by mail, could provide the writer with these data. Thus, the overall favorableness or unfavorableness of patients' WES-interval scores cannot be judged, but other findings presented in the two studies make possible comparisons of *groups* of patients in terms of degree of favorableness.
3. This number includes 18 samples from Table 2, one for each study listed, but only 20 samples from Table 3B. Two Table 3B studies—Klett et al. (1963) and Rice et al. (1963)—were not counted because the data for the total sample could not be calculated (see Note 2). Certain studies did not have to be counted, i.e., Friedman et al. (1974), Jones and Kahn (1964), Jones and Keener (1968), Kahn and Weber (1972), Moos and Houts (1968, 1970), Moos and Schwartz (1972), Moos et al. (1973), because the data for their total samples were available in other studies, viz., Konick (1971), Kahn and Jones (1969), and Moos (1974:60). Brady et al. (1959) and the veterans' hospital study of Souelem (1955), samples included in Table 2, were not counted twice. Thus, the 20 Table 3B samples considered are one each in 11 studies (Ellsworth and Maroney, 1972; Imre, 1962; Kish, 1971; Klass et al., 1977; Klopfer et al., 1956; Konick, 1971; Levinson and Gallagher, 1964; Pierce et al., 1972; Souelem, 1955; Spiegel and Younger, 1972; Wolfensberger, 1958), 2 samples in Roback and Snyder (1965), 3 samples in Moos (1974), and 4 samples in Kahn and Jones (1969).
4. Veterans' and university hospital samples only.
5. State hospital sample only.
6. The small number of patient samples taken from private, military, and general hospitals precluded meaningful comparisons with these types of psychiatric facilities.
7. The criteria devised here to evaluate the effects of social and psychiatric variables on the favorableness of patients' attitudes toward mental hospitalization obscured important relationships found in studies employing multiple measures. The requirement that half or more of the measures yield significant group differences, for example, was especially burdensome in the instances of Friedman et al. (1974) and Graham et al. (1974), who used 14 factors covering three scales, and of WAS researchers with 12 subscales. Frequently, patient groups in various samples differed significantly on *fewer* than half of the factors or subscales, but such differences were ignored in efforts to show an overall level of favorableness. These samples were perforce

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treated as instances in which social and psychiatric variables were "unrelated" to attitudes, but consideration of the relationships that did occur help explain the variations in findings for patient groups.

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